TO HOSPITAL OF

VS A15 (4) 15M 9/5B

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1355 CERTIFICATE OF DEATH 01345

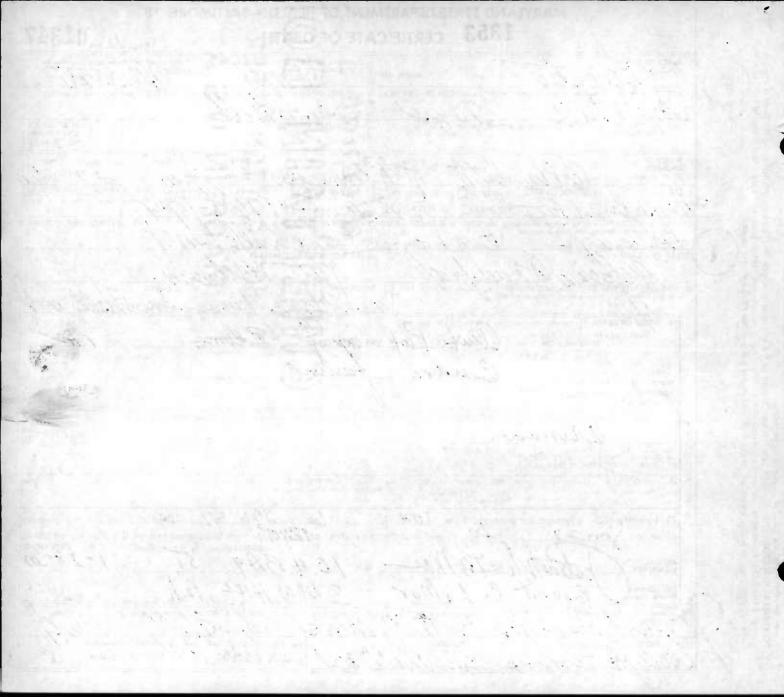
- OUT CERTIFIE	AIL OI DEAIII	Reg. Dist. No.
1. PLACE OF DEATH O. COUNTY MARYLAND	2. USUAL RESIDENCE (Where deceased a. STATE	lived. If institution: Residence befare admission) b. COUNTY
b. CITY OR TOWN (IP obside corporate limits, write RURAL and give nearest traval.	C. CITY OR TOWN (If outside corpora	ate limits, write RURAL and give nearest tawn)
d. NAME OF HOSPITAL (If nation hospital, give street address) OR INSTITUTION	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES NO
NAME OF DECEASED (Type or print) Was Dellaw	Baker 4. DATE OF DEATH	Month Day Year JAN 3 19 6
6. COLOR OR RACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED	B. DATE OF BIRTH FEB . 17, 1891	AGE (In years lost birthday) Months Days Hours Min.
00. USUAL OCCUPATION (Give kind of work dane dusing most of working life, even if retired) HOUSE VY (FE	STRY 11. BIRTHPLACE (State or foreign course) BERLIN	PFD. 12. CITIZEN OF WHAT COUNTRY
STRINGER HOLLAIND	14. MOTHER'S MAIDEN NAME HARRIETT R	ICHARDSON
15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. (If yes, give well of dates of service) 16. SOCIAL SECURITY NO. 17. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. 1	IS VI ROBERT &	BAKER BERYN MO
PART I. DEATH Enter only one couse per line for (a), (b), and (c) is part in the part in t	acoma ni	Ch 3 y 30
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT OF CONTRIBUTING TO DEATH BUT OF CONTRIBUTION TO DEATH BUT OF CONTRIBUTI		PERFORMED? YES NO
	ED. (Enter noture of injury in Part I or Port	il or item is.)
	LACE OF INJURY (Home, form, 20f. (City of city), street, affice bldg., etc.)	or tawn) (County) (State
21. 1 certify that I attended the deceased from 11.14 alive on 17.14 and that death		he causes and an the date stated abave eet, Eity or DATE SIGNEE
PHYSICIAN'S H. A. Briele	M.D. MUGUE Salesla	ear unsul 143 8
220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY C	DR CREMATORY 22d. LOCATION A H 7 M	ON/City, tawn, ar county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bulin	24a. RECID BY REGISTE	24b. REGISTRAR'S SIGNATURE Orthor S. Frank

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		2353 CERTIFICATE OF DEATH Reg. D/s	it. No. ()1347
Il director, filed with		1. PLACE OF DEATH o. COUNTY O. COUNTY MARYLAND 2. USUAL RESIDENCE (Where declased lived. If institutions perident d. STATE b. COUNTY b. COUNTY	e before semissian)
funera		b. CITY OR FOWN (If outside corporate limits, write RURAL and grant of the corporate limits and g	
70	X	d. NAME OF HOSPITAL (IF not in hospital, give street address) d. STREET ADDRESS d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES NO
Podes I and		3. NAME OF DECEASED (Type of print) Clisabeth 1 Downers le DEATH CM.	27 1960
	200	Temale White WIDOWED DIVORCED MIG. 8-1776 63/6/1990	1 YEAR IF UNDER 24 HRS Days Hours Min.
nd comple	death.	Helberge of working life, wen if retired) that Hame Jowellallo, mg	ZEN OF WHAT COUNTRY
physician ond		13. FATHER'S THAME TO COLOMBIA THE MOTHER'S MAJDEN NAME THE MOLEMAN	
	72 hau	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) (Yes, no, or unknown) (If yes, give war or dates of service)	Will mo
ottending	within	18. CAUSE OF DEATH [Enter only one cause per lim for (o), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) LEW PURPLE AND MANAGEMENT STATEMENT STATEME	INTERVAL BETWEEN ONSET AND DEATH
by the	ny even	782.4 DUE TO Conditions, if ony, which) (b) Conditions, if ony, which)	
signed	o ui pu	gave rise to immediate cause (a), stating the under-lying cause last.	
physicio os been	o loval, o	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART	1 (o) 19. WAS AUTOPSY PERFORMED? YES NO
ficote h	ar rem	20a. ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)	
ol or off	motion	20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED Haur o. m. While Not while of work of work of work of work 19 o	Caunty) (State
After the	riol, cre	21. I certify that I attended the deceased fram JBN 1, 1960, to JBN 27, 1960, that I la alive an 27, 1960 a, and that death accurred at 12/10 M, fram the causes and an the	
ECTOR:	ar to bu	ACTUAL SIGNATURE ADDRESS (Street, city or town, stote) ACTUAL SIGNATURE ADDRESS (Street, city or town, stote)	DATE SIGNE
ERAL DIR	ror pri	PHYSICIAN'S FROBER C. La Mar SNOW HILL, Md.	
TO FUNERAL DIRECT	he registror	226, BURIAL, CREMATION, 220. DATE THEREOF. 22. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City fown or county)	(Stote)
A15 (4)		23. FUNERAL DIRECTOR'S BIGNATURE (ADDRESS ADDRESS DATE AN 29'60 AND	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



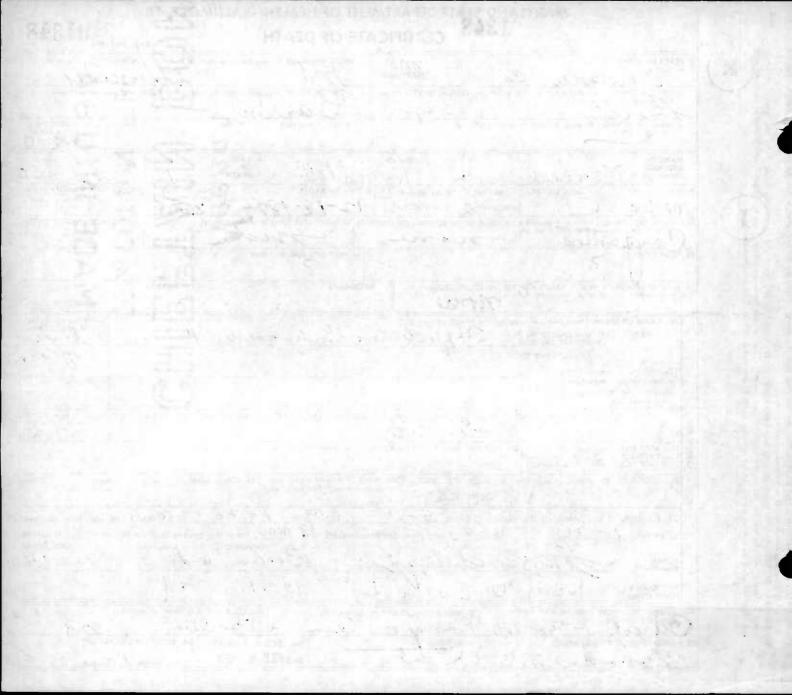
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HOSPITAL (FENDING PHYSICIAN: The law requires that the death certificate be executed within 24 ho		D FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and composely filled in by the funeral director,	6	the registrar priar to burial, crematian, ar remaval, and in any event within 72 haurs after deather
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1348 CERTIFICATE OF DEATH Reg. Dist. No PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNT b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CLTY OR TOWN (If autside carporate limits, write RURAL and give nearest town) RUKAL and give nearest town) d. NAME OF HOSPITAL (If nat in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS OR INSTITUTION ON A FARM? YES NO NAME OF 4. DATE First Middle Month Day Year DECEASED DEATH (Type or print) 196 IF UNDER I YEAR IF UNDER 24 HRS 5. SEX 6. COLOR OR RACE 7. MARRIED T NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years last birthday) Months Days Hours WIDOWED DIVORCED 5 yrs. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) dyring most of working fife, even if retired) 12. CITIZEN OF WHAT COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT Address 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED 8Y IMMEDIATE CAUSE (o 443X DUE TO Conditions, if any, which gave rise to immediate DUE TO cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Port II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) WEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) (County) (Stote) factory, street, affice bldg., etc.) Hour o. m. While Not while at wark ot wark 1960 that I last saw the deceased 21. I certify that I attended the deceased fram and that death occurred at 8: 46A M, fram the causes and an the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE PHYSICIAN'S OT NAME (Type) 22a. BURIAL, CREMATION, 22b. DATE THEREOF 22d. LOCATION (City, town, or county) 22c, NAME OF CEMETERY OR CREMATORY (State) REMOVAL (Specify) 24b. REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24a. REC'D 8Y REGISTRAR

DATEFEB 9

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O E O G VS A15 (4) 15M 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01349

350 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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Rea.	Dist.	No.				

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TO DEPUTY M. IL EXAMINER: This certificate should be executed within 24 hours after death. If ony delay place, execute the cose, writing the word "pending" in pendi in them 18. Give Pages 1, 2, and 3 to the fun.

4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremotion, or removal, and its within 72 hours ofter death.

2

VS. A15ME 5M 2/57

B. CITY OR TOWN (in enable experted lamin, write BURAL ord give neeres) C. LENGTH OF STAY IN 1b			LACE OF DEATH								ed lived. If institu		nce bef	are admi	ssion)
Do Gott Versego Colty d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give firest address) 910 Second Street 911 Month 912 CITIZEN OF WHAT 105 Month 105 Month 105 Month 105 Month 105 Month 105 Month 106 Month 107 Month 108 Month 108 Month 109 Month			W				MARYLAND	o. STATE	Mary	land	b. COUNT	Wor	ce	ster	
A NAME OF HOSPITAL OF INSTITUTION (If not in hospital, give firest address)			and dive pensesi towni						OR TOWN (II	f autside carp	orale limits, write	RURAL and	give ne	earest for	wn)
910 Second Street Same		P	ocomoke	City		ye	ars	42	Pocor	moke (City				
3. NAME OF STATES AND		-			(If not in hos	pital, give street	address)	d. STREE						e. IS RE	A FARM?
S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH S. AGE In percent S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH S. AGE In percent S. DATE OF BIRTH S. DATE O		9	10 Secon	d Street				1	910	Second	d Stree	t		YES [NO
S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH WIDOWED DIVORCED NOV. 27, 1873 9. AGE Instantial poly Months Days		3. N	NAME OF	Fir	rst	Mid	dle	L	leo.		Monti	1	Day	Y	ear
Female White WIDOWEDED DIVORCED Nov. 27,1873 Restablished Months Doys Hours Nov. 27,1873 Restablished Nov. 27,1873 Restablis		(Type or print)	ANNI	E	DEPUTY	CI	ROASDA	ALE	DEATH		ry	31		960
Temale White Middle Mi		5. SI	EX	6. COLOR OR RACE	7. MARRIE	D NEVER M	ARRIED B.	DATE OF BIE	RTH		last birthday)				Min.
Delaware USA Housewife Id. Mother's Maiden Name John W. Cross delay Deputy Martha W. Clogg Id. Mother's Maiden Name Martha W. Clogg Address Id. Mother's Maiden Name Martha W. Clogg Id. Mother's Maiden Name Martha W. Clogg Address Id. Mother's Maiden Name Martha W. Clogg Martha W. Clogg Id. Mother's Maiden Name Martha W. Clogg Maderess J.C. Stevenson, Pocomoke City, Md. Id. Could Name Martha W. Clogg Id. Could Name Martha W. Clogg Id. Clogge Id. Clogge Maderess J.C. Stevenson, Pocomoke City, Md. Id. Clogge Id.		-					- 17		27,187	73		Mollina	ooy.	110013	Will.
Delaware		10a.	usual occupation	N (Give kind of work life, even if retired)	dane 10b. K	IND OF BUSINES	S OR INDUST				ountry)	2.1		WHAT	COUNTRY?
John W. Crossdale Deputy Martha W. Clogg 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address 17. INFORMANT Address 17. INFORMANT Address 17. INFORMANT J.C. Stevenson, Pocomoke City, Md.							11.63	De	lawa	re		J	JSA		
15. WAS DECEASED EVER IN U. S. ARMED FORCEST 16. SOCIAL SECURITY NO. 17. INFORMANT 17.				F-330	11.045			14. MOTHER	S'S MAIDEN I	NAME					
		-		and the second second second		ty			artha	W. C.	logg				
18. CAUSE OF DEATH [Enter only one course perfine (d) (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. DUE TO Conditions, If any, which gave rise to immediate cause (o), toloing the underlying (c). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS A PERFORMANT OF CONTRIBUTING DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS A PERFORMANT OF CONTRIBUTING DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS A PERFORMANT OF CONTRIBUTING DEATH. 200. EXTERNAL CAUSE WAS PRIMARY DOCUMED 10. ENJOy for course of injury in Part I or Part II of item 18.) CAUSE OF DEATH. 200. EXTERNAL CAUSE WAS PRIMARY DOCUMED 10. INJURY OCCURRED 10. Injury in Part I or Part II of item 18.) CAUSE OF DEATH. 201. Certify that I taak charge of the remains described above, held an Autopsy Inspection Inquiry opinian death resulted from Natural causes Accident Assistant Medical Examiner DATE SI GINATURE ACTUAL SIGNATURE EXAMINER'S No E SARTORIUS, SR. DEPUTY MEDICAL EXAMINER DATE SIGNATURY (City, town, or county) PART II. DEATH WAS CAUSED BY THE DISTANCE OF INJURY (Home, form, 204. (City or town) (County) CAUSE OF DEATH. ASSISTANT MEDICAL EXAMINER DATE SI ASSISTANT MEDICAL EXAM			WAS DECEASED EVE	R IN U. S. ARMED FO	RCES? 16.	SOCIAL SECURITY									
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20c. TIME OF INJURY Hour o. m. P. m. 19 of work of wor		ERTIF	PRIMARY or CON	SE WAS	0b. DESCRIBE	HOW INJURY	OCCURRED. (F	nter profure of	injury in Par	rt I or Part II	of item 18.)				
21. I certify that I taak charge of the remains described above, held an Autopsy, Inspection, Inquiry, and opinion death resulted from Natural causes, Accident, Suicide, Homicide, Undetermined manner ACTUAL					- Inc. 1	/ /	20 00			Table 100					
21. I certify that I taak charge of the remains described above, held an Autopsy, Inspection, Inquiry, and opinion death resulted from Natural causes, Accident, Suicide, Homicide, Undetermined manner ACTUAL		00	4.0	T Month, Day, 1e			f	ery, street, off	ice bidg., elc	n, 120f. (City :.)	or lawn)	(Cou	nty)		(State)
opinian death resulted from Natural causes [], Accident [], Suicide [], Homicide [], Undetermined manner [] ACTUAL SIGNATURE [] EXAMINER'S NAME (Type) N. E. SARTORIUS, SR. DEPUTY MEDICAL EXAMINER [] 220. BURIAL (REMATION. 22b. DATE THEREOF 22c. NAME OF CEMETERYXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX		ME	p. m.			Lad.									
ACTUAL SIGNATURE EXAMINER'S N. E. SARTORIUS, SR. DEPUTY MEDICAL EXAMINER 220. BURIAL CREMATION. 22b. DATE THEREOF 22c. NAME OF CEMETERYXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX			21. I certify th	at I taak charge	e of the r	emains desc	ribed abo	ve, held o	an Autops	iy 🔲, Ir	nspectian [],	Inquir	у 🔲	an	d in my
SIGNATURE EXAMINER'S NAME (Type) Page 1220. Burial, Cremation, 122b. Date thereof REMOVAL (Specify) Burial 220. Salem Methodist Pocomoke City, Maryla			opinian death	recurred from	Natural c	auses	Accident [, Suici	ide 🔲,	Homicide	, Undete	rmined n	nanne		
SIGNATURE EXAMINER'S NAME (Type) Page 1220. Burial, Cremation, 122b. Date thereof REMOVAL (Specify) Burial 220. Salem Methodist Pocomoke City, Maryla			ACTUAL /	10	1-1	paris .	10	,						DATE S	IGNED
EXAMINER'S N. E. SARTORIUS, SR. DEPUTY MEDICAL EXAMINER 2 220. BURIAL (SPECITY) BURIAL (Specity) 220. DATE THEREOF 220. NAME OF CEMETERYXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX			SIGNATURE).V:	an	valls	-10	_ M.D.						_/	11
220. BURIAL CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX				AT TO CLAT	DEC D.T.	an an								1/2	60
Burial 2-3-60 Salem Methodist Pocomoke City, Maryla														//	
Burial 2-3-60 Salem Methodist Pocomoke City, Maryla			_REMOVAL (Specify)		OF								,	1	'
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1 FOR STATE		Ιt	em 20 Film 20 ARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 135 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No. ()135()
HEALTH DEPT		1. P	LACE OF DEATH COUNTY (C) MARYLAND 2. USUAL RESIDENCE (Where deeposed lived. If institution, Regidence before admission) o. STATE MARYLAND D. COUNTY (C) B. COUNTY (C)
Sory, please ectar. Page your files. d of Health)		CITY OR TOWN (If outside corporate limits, write RURAL ond give neorest town) ond give neorest town) AMME OF HOSPITAL OR INSTITUTION (If not in hospital, give statest address) On the control of the corporate limits, write RURAL and give neorest town) On the corporate limits, write RURAL and give neorest town) On the corporate limits, write RURAL and give neorest town) On the corporate limits, write RURAL and give neorest town) On the corporate limits, write RURAL and give neorest town) On the corporate limits, write RURAL and give neorest town) On the corporate limits, write RURAL and give neorest town)
h. Boar		0	NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give fixed oddress) O. STREET ADDRESS O. IS RESIDENCE ON A FARM? YES NO
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2. and Page 5 and 2 and 2		10o.	USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY) (1. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY?
PM3. I withi		13.	FATHER'S NAME 1
Give Porm th form File p	1	15. (Yes,	WAS DECEASED EVER IN U. S. ARMED FOREISS? 16. SOCIAL SECURITY NO. 17. INFORMANY Address Add
long with	/		18. CAUSE OF DEATH [Enter only one course per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BSPHYX IN TIOW (HOUSE FIRE) IMMEDIATE CAUSE (a)
fice of frontier o			916.0 DUE TO
buriali buriali		-	Canditions, if any, which gave rise to immediate cause (a), stating the underlying DUE TO
Examira d as a lation,	0	NO	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19, WAS AUTOPSY PERFORMED?
pen in pen dical		TIFICAT	ATTACKS OF SYNCOPE PAST FEW MONTHS YES NO RESTRICTION OF STREET OF
ward ward ward ward berial		AL CERTIF	PRIMARY or CONTRIBUTING She set fire to the home by dropping the kerosene lamp. 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or fown) (County) (State)
ing the Charles or to	3	MEDIC	While of work
EXAM e, write ed to R: Po			21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from; Natural codies , Accident , Suicide , Hamicide , Undetermined manner
forwards DIRECTO			ACTUAL DATE SIGNED
orty Me the the the the the the the the the th	2		ASSISTANT MEDICAL EXAMINER [] /-/8-60
Share its	1	270	NAME (Type) Robert 6. Lamar, M. D. DEPUTY MEDICAL EXAMINER DE PUTY MEDI
2 4 2 6 VS. A15ME	1	L	FUNERAX DIRECTOR'S SIGNATURE DODRESS 1 240. REC'D BY REGISTRAR'S SIGNATURE
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1349 CERTIFICATE OF DEATH

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707	3 CERTIFICATE OF DEATH	Reg. Dist. No.
1. PLACE OF DEATH O. COUNTY, A C RECSTER	MARYLAND O. STATE	eased lived. If institution: Residence before admission) b. COUNTY / IRC ESTER
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside of	orporate limits, write RURAL and give nearest town)
 NAME OF HOSPITAL (If not in hospital, give street addr OR INSTITUTION 	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type or print) SAMUEU	Middle Last 4. DA	ATH JAN. 27 19 6
S. SEX 6. COLOR OR RACE 7. MARRIED WIDOWED	NEVER MARRIED B. DATE OF BIRTH DIVORCED ANE 25, 18	9. AGE (In years let UNDER 1 YEAR IF UNDER 24 HRS lost birthday) Months Days Hours Min.
10o. USUAL OCCUPATION (Give kind of work done of the control of working life, even if retired) 13. FATHER'S NAME	DOF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign C S MAN OCGAN C1	gn country) 12. CITIZEN OF WHAT COUNTRY
SAMUEL J. MONK	CHOUSE LAURA J.	TAYLOR.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOC (Yes, no, or unknown) (If yee, give wor or dates of service)	IAL SECURITY NO. INFORMANT MR BUMINS M	Address ANITHOUSE OCEAN
1B. AUSE OF DEATH [Enter only one couse per line for PART I. DEATH WAS CAUSED BY:	r (o), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
1420.1 DUE TO	n ary Cocleration	Ja Is brees
Conditions, if ony, which) (b) (aster	405 dles ous	2 420
gave rise to immediate couse (a), stating the under-lying couse lost.		
CATIC	TRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DIS	SEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO N
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	E HOW INJURY OCCURRED. (Enter nature of injury in Port I or	Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Year While of work	Not while foctory, street, office bldg., etc.)	(City or town) (County) (Stote)
21. I certify that I attended the deceased f	fram. , 1957 , ta Just	27, 1959, that I last saw the deceased
alive an 100 27 , 19 39		am the causes and an the date stated abave
ACTUAL SIGNATURE	as M.D. Ocoaca	Jaly mid 1/31/40
PHYSICIAN'S NAME (Type) NING THE THE	AS OCPAN	City / rde 1/2/60.
220. BURIAL, CREMATION, 22b. DATE THEREOF 220.	C. NAME OF CEMETERY OR CREMATORY 22d. LC	SALTIMORE MD
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS 24g. REC'D BY RE	GISTRAR 24b. REGISTRAR'S SIGNATURE
Janua ot - pure tyle	DATE PEB 2	60 ariling S. Hraus

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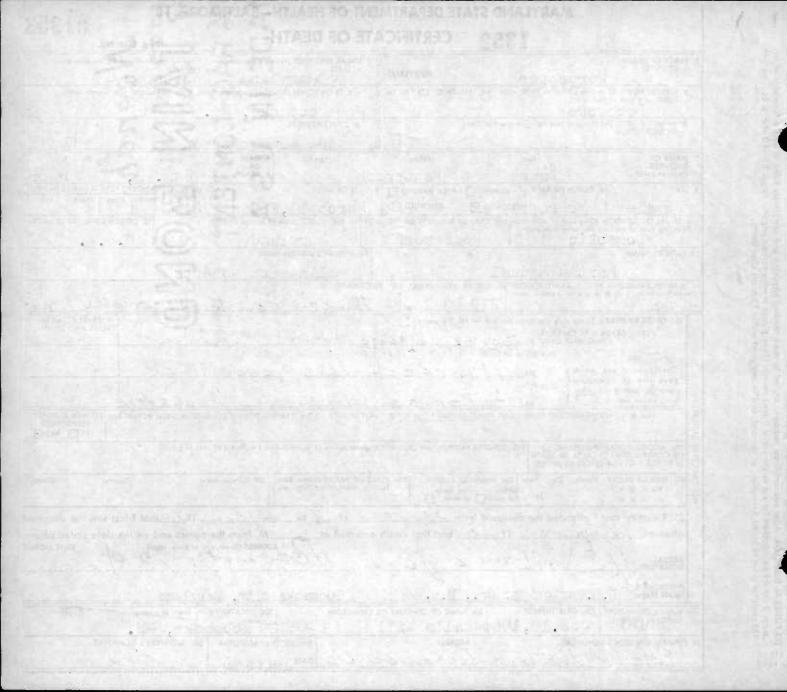
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9	352	CERTIFICATE	OF DEATH

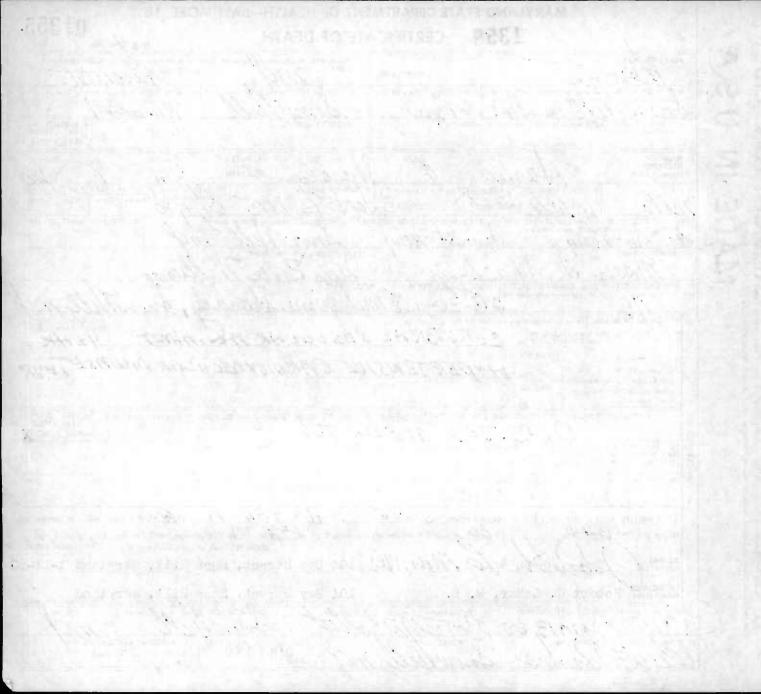
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		LUU.					K	eg. Dist. No	•
1, PLACE OF DEATH o. COUNTY	Worcester	r	MARYLAND	o. STATE	dence (wh Marv]	ere deceased live	d. If institution: b. COUNTY WOTCES		re admission)
RURAL ond give no	f outside corporate limit		c. LENGTH OF STAY IN 16	c. CITY OR		utside corporote I			arest town)
	AL (If not in hospitot, g	ive street o	oddress)	d. STREET A			14.3		e. IS RESIDENCE ON A FARM?
	Home			50	4 YOI	ing Str	eet		YES NO C
3. NAME OF DECEASED (Type or print)	Laui		Middle Patter;	los SON	st	4. DATE OF DEATH	Month Jan.	2.	Yeor 19 60
5. SEX Female	6. COLOR OR RACE	7. MARR	D DIVORCED	8. DATE OF BIRT		1885 9. Ai		Onths Days	Hours Min.
10o. USUAL OCCUPATION during most of work		done 10b.	KIND OF BUSINESS OR INDU Housework	STRY 11. BIRTHPL	aryla	or foreign country		U.S.	F WHAT COUNTRY
13. FATHER'S NAME				14. MOTHER'S	MAIDEN N	AME			
	lartin Mar				izabe	eth Rob	erts		
15. WAS DECEASED EVE (Yes, no. or unknown)	R IN U. S. ARMED FOR: (If yes, give wor or dotes of se		SOCIAL SECURITY NO. 17. 1	Tiel	cie à	Deligato	Address	omol	a mg
Conditions, if or gove rise to it couse (o), stoting lying couse lost.	ny, which (b) (b) DUE TO (c)	A-DITIONS C	therosc,	lerosi lerosi	S'IS	thera		Vete	9 WAS ALITOPSY
TE CAT	22 10 32 10							11417711(0)	PERFORMED? YES NO 1
	S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	20b. DESC	TRIBE HOW INJURY OCCURRE	D. (Enter nature o	if injury in P	ort I or Part II of	item 18.)		
20c. TIME OF INJUR Hour o. m. p. m.	Y Month, Day, Yea 19	While	Not while of work	ACE OF INJURY (I ctory, street, office	Home, form, e bldg., etc.	20f. (City or to	own)	(County)	(Stote)
actual SIGNATURE	E Jan	19 G	ed from 23 Oct	M.D.	Pod	M, from the	causes and	an the da	te stated abave DATE SIGNE
220. BURIAL, CREMATIO	N. 22b. DATE THEREO		22c. NAME OF CEMETERY O			City M.			
REMOVAL ISpecty)	Jan.10.				5	-	moke.		(Stote)
23. FUNERAL DIRECTOR'S	S SIGNATURE	070 -	ADDRESS - accomo	c, Ua		BY REGISTRAR	24b. REGISTRA	AR'S SIGNATU	RE



HA.		AST CONTRACTOR
The state of the state of	Name of the Paris	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



	RAL DINACTOR: After this certificate has been signed by the attending physician and campletely filled in the funeral director,	should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shauld be filled with	/	
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The state of discious and state of the state	1	P.	istrar priar to burial, cremation, ar remayal, and in any event within 72 hours after-death.	
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ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 house

	orrender	en please	nithin it
1	lued by Inc	bermit. The	in any ever
physician.	nds Deen sig	rial-transit p	mayal, and
or attending	certificate	se as the bu	alian, ar rei
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H CO	STATE OF THE PERSON AND PERSON AN	id be deto	prior to b
The may be retail the haspital or attending physician.	TO PUNEKAL	page 3 shan	the registrar prior to burial, cremation, or remayal, and in any event within
S A 5M	9/	(4) 55	

o. COUNTY	rcester	MARYLAND	o. STATE Maryla	and	b. COUNTY	Norces	ter	iony
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town)					
Bishop	Rural	Life	X Bishop, Rural					
	TAL (If not in hospital, give street	address)	d. STREET ADDRESS				e. IS RES ON A YES	SIDENCE A FARM? NO
3. NAME OF DECEASED	First	Middle	Lost	4. DATE OF	Mon			Year
(Type or print)	Charles	М.	Showell	DEATH	O CTITUELT			1960
5. SEX	6. COLOR OR RACE 7. MAR		B. DATE OF BIRTH		9. AGE (In years lost burthday)	Months Do		ER 24 HRS. Min.
Male	Colored widow			374	05 yrs.			
10a. USUAL OCCUPATION during most af war	ON (Give kind of work dane 10b king life, even if retired)	KIND OF BUSINESS OR INDU	JSTRY 11. BIRTHPLACE (State	ar foreign c	ountry)	12. CITIZE	N OF WHAT	COUNTRY
Farmer		Farming	Marylar	nd		Unit	ed St	tates
13. FATHER'S NAME			14. MOTHER'S MAIDEN	NAME				
Unknown			Unknown					
15. WAS DECEASED EVE	R IN U. S. ARMED FORCES? 16	SOCIAL SECURITY NO. 17.	INFORMANT		Addr	ess		
No	(ii yos, give won or odica or torrice)	None Wa	alter Showel	11	Bishor	. Mar	vland	3
18. CAUSE OF DEA	ATH [Enter only one cause per l						INTERVAL BE	TWEEN
PART I. DEA	TH WAS CAUSED BY:	Historila	ione Cu	dean	seular		ONSET AND	DEATH
443x	DUE TO	11	0.		0 —		Sever	ne
Canditions, if a	one which \						yea	u
gave rise to i	mmediate (1	
lying cause last.	the under-							
	HER SIGNIFICANT CONDITIONS	CONTRIBUTING TO DEATH BU	T NOT RELATED TO THE TERM	INAL DISEAS	E CONDITION GIV	EN IN PART II	a) 19. WAS	AUTOPSY
PART II. OTI		Eteme, to					PERFO	NO
	AS UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	SCRIBE HOW INJURY OCCURR	ED. (Enter nature of injury in	Part I or Par	t II of item 18.)			140
20c. TIME OF INJUS Hour o. m. p. m.	RY Month, Day, Year 20d. White at wa	Not while fo	LACE OF INJURY (Hame, farm actory, street, affice bldg., etc	n, 20f. (City	or tawn)	(Cau	nty)	(State)
21 I certify th	nat I attended the decea	sed from 3-2	0 1957 to	1-7	5 1060	that I las	t saw the	decease
alive on	1 7.6		accurred at 4:30	M from	n the causes a			
dire on	0	'A			treet, city or town,			ATE SIGNE
ACTUAL	trong U.	Quely of	8 (2)	elin	- mo		1-	-27-
SIGNATURE	1	* ()	M.D.					
PHYSICIAN'S INAME (Type)	ory U. Sully	Jr.						
	ON, 22b. DATE THEREOF	22c. NAME OF CEMETERY	OR CREMATORY	22d. LOCA	TION (City, town, o	or county)	(Stat	e)
REMOVAL (Specify) Burial	Jan. 29/60	Long's Cer	netery	Sel	byville	. De	lawar	ce
23. FUNERAL DIRECTOR		ADDRESS	24a. REC	D BY REGIST	RAR 24b. REGIS	TRAP'S SIGNI	ATLIPE	
Idenses Ja	, Watson	Pocomoke	Md. DATE F	EB 1	60	Allan S.	Conce	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

